pa health & wellness

HEDIS® 2021 (MY 2020)

Transitions of Care (TRC)

We are committed to working with you to improve the quality of care and health outcomes for your patients, our members. The Healthcare Effectiveness Data and Information Set (HEDIS®) tool is used to measure many aspects of performance. This tip sheet details some of the key features of the HEDIS® measures for Transitions of Care.

Measure Definition	The percentage of discharges for members 18 years of age and older who had each of the following. Four rates are reported: • *Notification of Inpatient Admission*. Documentation of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days). • *Receipt of Discharge Information*. Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days). • *Patient Engagement After Inpatient Discharge*. Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge. • *Medication Reconciliation Post-Discharge*. Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days). Medication Reconciliation: A type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record. Medication List: A list of medications in the medical record. The medication list may include medication names only or may include medication names, dosages and frequency, over-the-counter (OTC) medications and herbal or supplemental therapies.

Lines of Business	Medicare

HEDIS 2021 Updates	Revised the time frame for the Notification of Inpatient Admission and receipt of Discharge Information indicators to the day of admission/discharge through 2 days after the admission/discharge.

Required Documentation: Notification of Inpatient Admission	Documentation of receipt of notification of inpatient admission on the day of admission or the following day. **Measure Compliance:** Documentation in the outpatient medical record must include evidence of receipt of notification (time/date stamped) of inpatient admission on the day of admission or the following day. **Examples:** Communication between the emergency department (ED), inpatient providers or staff and the member's primary care physician (PCP) or ongoing care provider (e.g., phone call, email, fax). Communication about the admission to the member's PCP or ongoing care provider through a health information exchange; an automated admission via ADT alert system; or a shared electronic medical record. Indication that a specialist admitted the member to the hospital and notified the member's PCP or ongoing care provider. Indication that the PCP or ongoing care provider placed orders for tests and treatments during the member's inpatient stay. Indication that the admission was elective and the member's PCP or ongoing care provider was notified or had performed a preadmission exam.

Required Documentation: Receipt of Discharge Information	Documentation of receipt of discharge information on the day of discharge or the following day. **Measure Compliance:** Evidence of the date when the documentation was received. Information must include: practitioner responsible for member's care during the inpatient stay; procedure or treatment provided; diagnosis at discharge; current medication list; testing results or documentation of pending test or no test pending; instructions for patient care. **Examples:** Discharge information may be included in a discharge summary or summary of care record or be located in structured fields in an electronic health record.

Required Documentation: Patient Engagement After Inpatient Discharge	Documentation of patient engagement (e.g., office visit, visit to the home, or telehealth) provided within 30 days after discharge. Do not include patient engagement that occurs on the date of discharge. **Measure Compliance:** Documentation in the outpatient record must include evidence of patient engagement within 30 days after discharge. **Any of the following meet criteria:** Outpatient visit (including office and home visits); telephone visit; synchronous or asynchronous telehealth visit. ***Note:*** If the member is unable to communicate with the provider, interaction between the member's caregiver and the provider meets criteria

Required Documentation: Medication Reconciliation (MRP)	Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or RN on the date of discharge through 30 days after discharge. **Measure Compliance:** Documentation in the outpatient medical record must include evidence of medication reconciliation and the date when it was performed. ***Note:*** Only documentation in the outpatient chart meets the intent of the measure, but an outpatient visit is not required. If the member was transferred from one inpatient facility to another (e.g., hospital to a skilled nursing facility (SNF), the medication reconciliation will be upon patient discharge from final inpatient facility stay (e.g., upon discharge from SNF).

Exclusions	Members who use hospice services or elect to use a hospice benefit, regardless of when the services began in the measurement year.

Best Practices: Improving HEDIS Scores	• Check the EMR for open care gaps. • Work with your PHW Provider Relations Representative to understand your TRC metrics and how to address care gaps. • Clearly document reconciliation of discharge medications with current medications. • Clearly document if no medications were prescribed or ordered upon discharge. • See or speak with patients within 30 days of discharge.

Common Codes*

Description	Codes
Outpatient Visits	**CPT:** 99201–99205, 99211–99215, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99429, 99455, 99456, 99483
Telephone Visits	**CPT:** 98966-98968, 99441-99443
Transitional Care Management Services	**CPT:** 99496, 99495

*codes subject to change